Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING: <b>01</b>			X3) DATE SURVEY COMPLETED		
		HAL096008	B. WING		04/0	7/2016		
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
WOODARD CARE 2050 US 70 WEST HWY GOLDSBORO, NC 27534								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
C 000	Initial Comments		C 000					
	Frank Strickland or							
	indicates that this fa 07/01/1990 as a HA Special Care Unit of currently licensed for facility was surveyed applicable portions Licensing of Adult of Beds and the 1987 Regulations for Hot applicable portions 1999 Editions of the Code(s)- Institution	peen cited and a Plan of						
C 189	SECTION .0300 - F 10A NCAC 13F .03 REQUIREMENTS (a) The building an mechanical, and plucare home shall be operating condition (k) This Rule shall facilities with the ex-	11 OTHER  Id all fire safety, electrical,  umbing equipment in an adult  maintained in a safe and	C 189					
	been maintained pe through fire-rated c	et as evidenced by: ations, this facility has not enetrations due to breaches onstruction invalidated its struction. This could affect all						

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
		HAL096008	B. WING		04/0	7/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
WOODARD CARE 2050 US 70 V							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE COMPLETE		
C 189	Continued From page 1		C 189				
		in the event that a fire and/or ned in a room or compartment					
	Findings on 04/07/2016: There is an opening in the concrete block from the sink waste line that is located in the Men's Memory Care Unit.						
	maintained in a safe penetrates the roof affect all residents a	ation, the facility has not e manner piping that ceiling assembly. This will and staff in the event that fire t contained in a room or gin.					
		riser supply pipe that ng is not sealed that is located					
	maintained in a safe the corridor handra	ation, the facility has not e and operating condition of lls. This could affect all ing grasping support for ht.					
	Findings on 04/07/2 The corridor handra	2016: ail is loose outside Room 1.					
	maintained in a safe the closures on inte	ation, the facility has not e and operating condition of rior doors. This could affect all and/or smoke from the gin.					
	the closure arm act	2016: unfastened to the door and s as a wedge to prevent the or located in the Visitor Men's					

Division of Health Service Regulation

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		HAL096008	B. WING		04/0	7/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DDRESS, CITY, STATE, ZIP CODE				
WOODA	RD CARE		70 WEST HW				
WOODA	ND OAKE	GOLDSBO	ORO, NC 27	534			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
C 189	Continued From page 2		C 189				
	Bathroom.						
C 199	Exhaust Ventilation		C 199				

Division of Health Service Regulation STATE FORM